BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARTIN S. CHATTMAN, M.D.** Holder of License No. 7618 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-09-0279A **CONSENT AGREEMENT FOR DECREE OF CENSURE AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Martin S. Chattman, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any

waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[V]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

12. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot act as a supervising physician for a physician assistant while his license is restricted.

13. ***Respondent has read and understands the conditions of probation.***

DATED: 7-16-09

MARTIN S. CHATTMAN, M.D.

REVIEWED AS TO FORM:

DATED: 7.16.09

PAUL J. GIANCOLA

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 7618 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-0279A after receiving a complaint regarding Respondent's care and treatment of a fifty-six year-old female patient ("SR").

4. In December 1997, SR established care with Respondent for reported migraine headaches. Respondent's initial evaluation did not include a documented review of any prior medical records or diagnostic testing. Over the next four years, with the exception of between May 2000 and January 2002, Respondent prescribed large

quantities of codeine/barbiturate products and benzodiazepines. There was no documentation of SR's headaches, her response to the medications, any side effects or whether Respondent monitored her compliance with the medications. Respondent's records for SR were sparse and did not include a treatment plan; however, there was documentation that SR was at high risk for substance misuse and on June 28, 1999, SR reported an episode regarding lost medications. However, there was no indication that Respondent followed up on this.

5. In 2002, 2003 and 2004 Respondent recommended SR obtain psychiatry and neurology consultations; however, SR did not obtain the recommended specialist consultations for migraine or psychiatric conditions documented in the medical records. In 2004, a family member contacted Respondent and reported that SR did not take the medications as directed and that she was addicted. In response, Respondent discussed with SR her use of pain medications and addiction, and referred her for pain management and psychiatric consultations, but SR refused. Respondent continued to prescribe for SR's various acute and chronic complaints large quantities of codeine containing products and benzodiazepines on a frequent basis. In October 2002, January 2003 and July 2005, Respondent noted that SR was seeing a neurologist. In 2006 and 2007, there was only one documented office visit for each year for worsening headache pains; however, Respondent prescribed large quantities of codeine containing tablets, Diazepam tablets and controlled substances to SR without documenting an associated office visit or any indication for the prescriptions.

6. Respondent stated that he was not aware that SR was also seeing at least five other prescribers for medication. Respondent continued to prescribe benzodiazepines and Fiorinal through September 2008 even though SR reported in February 2008 that she had obtained medications over the internet. Respondent documented that he had a

growing sense that ongoing prescribing was not in SR's best interest he encouraged her to take less medication and see a pain specialist; however, the prescribing continued. Subsequently, in September 2008, SR informed Respondent that she was moving to California and requested a prescription for Fiorinal in an amount sufficient to last until she was able to establish care with a new physician. Respondent provided SR with an early renewal for Fiorinal with refills. Respondent noted that he would no longer provide prescriptions for SR. Two weeks later, SR died from an overdose.

7. The standard of care for prescribing long-term opioid medications for chronic nonmalignant pain requires a physician to perform appropriate evaluations of the pain problem, obtain a history and perform a targeted physical exam that includes reviewing past medical records and medication history; to monitor the patient for efficacy and adverse effects of the medications and to recognize and follow up on problems suggestive of noncompliance and/or aberrant drug seeking.

8. Respondent deviated from the standard of care because he did not perform appropriate evaluations of SR's pain problems, obtain her history or perform a targeted physical exam that included reviewing her past medical records and medication history; he did not monitor SR for efficacy and adverse effects of the medications and he did not recognize or follow up on problems suggestive of noncompliance and/or aberrant drug seeking.

9. SR fatally overdosed. SR's worsening headache pain may have been due to analgesic rebound and overprescribing. There was potential of perpetuation of addictive tendencies and brain damage.

10. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and

cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did not document a review of any prior medical records or diagnostic testing; he did not document SR's headaches, her response to the medications, any side effects or whether Respondent monitored her compliance with the medications; he prescribed medications without documenting an associated office visit or any indication for the prescriptions and SR's records were sparse and did not include a treatment plan.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."), A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."), and A.R.S. § 32-1401 (27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Respondent is placed on a practice restriction for **ten years** with the following terms and conditions:

a. Respondent is prohibited from prescribing, administering, or dispensing any Controlled Substances.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. This Order is the final disposition of case number MD-09-0279A.

DATED AND EFFECTIVE this 5TH day of AUGUST, 2009.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed
this 6th day of August, 2009 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 6th day of August, 2009 to:

Martin S. Chattman, M.D.
Address of Record

Kaynda Corley
Arizona Medical Board Staff